TREATMENT OF PATIENTS WITH MENTAL ILLNESSES IN THE EMERGENCY DEPARTMENT: A BEST PRACTICE APPROACH

By

KELSEY RACHELA HILL

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Approved by:

Dr. Wanda Larson, PhD, MEd, RN, CEN
College of Nursing

Judith E. Nolen, MS, RN, BC
College of Nursing
Treatment of Patients with Mental Illnesses in the Emergency Department:

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Kelsey Rachela Hill

The University of Arizona

College of Nursing
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ABSTRACT

The purpose of this thesis was to develop evidence based recommendations for best practice in nursing care of patients with mental illnesses in the emergency department. It is estimated that one in about every four individuals in the United States has been diagnosed with a mental illness (National Alliance on Mental Illness, 2013). Additionally, it is estimated that one in every eight emergency department visits will be related to patients with mental illnesses or substance abuse (Manton, 2013). However, studies suggest that staff members do not feel comfortable caring for patients with mental illnesses and many staff members hold biases against patients with mental illnesses (Manton, 2013). Therefore, this thesis proposes a best practice protocol the better educate staff members on providing appropriate care to patients with mental illnesses in the emergency department. Additionally, this protocol proposes a debriefing program to help staff manage stress if violent events do occur.
CHAPTER 1

Statement of Purpose

The purpose of this thesis was to develop evidence based recommendations for best practice in nursing care of patients with mental illnesses in the emergency department (ED). The recommendations address staff education in regards to the assessment of patients for escalating behaviors, intervention methods for de-escalation, and post violent incidence debriefing. Background regarding treatments of patients with mental illnesses is presented, including a historical perspective, current perspectives, and significance of the problem. This information then provides a foundation for a review of the literature. A best practice protocol is then developed for assessing and treating patients with mental illnesses in the emergency department.

Background: Historic Perspective on Mental Illnesses

The need for individuals with mental illnesses to be better connected with healthcare resources was recognized as early as 1840. However, the treatment of patients with mental illnesses during this time was primarily restricted to prisons and asylums (Townsend, 2014). The purpose of placing individuals with mental illnesses in prisons and asylums was to protect the patient from harming himself or herself, harming others, or being harmed by others (Townsend, 2014). Beginning in 1841, Dorothea Dix was one of the first individuals to campaign for a more humane treatment of patients with mental illnesses (Townsend, 2014). As a result of her efforts, 110 psychiatric hospitals were built in the United States between 1841 and 1880 (Townsend, 2014). The shift from placing individuals with mental illnesses in prisons or asylums to the establishment of psychiatric hospitals was an indicator that mental illnesses were beginning to be understood as a serious condition that required attention and treatment. However, due to the increasing number of patients with mental illnesses, it quickly led to overcrowding and poor
conditions at the state hospitals (Townsend, 2014). Then in 1877, Nellie Bly falsified a mental illness diagnosis in order to be admitted to the Lunatic Asylum in New York (Townsend, 2014). She then published an article in the New York World titled “Ten Days in a Madhouse,” which drew public attention to the poor living conditions at the state hospitals and asylums (Townsend, 2014). This article led to a grand jury trial, which ultimately ended in an increase in funding for the asylum (Townsend, 2014).

It wasn’t until the 1940s that improving the treatment of patients with mental illnesses was again brought to the attention of the federal government and the general public. During this time, the United States Federal Government passed several acts in an attempt to improve the quality of care for patients with mental illnesses. In 1946, President Truman signed the National Mental Health Act into law (Koyanagi, 2007). This law established the National Institute of Mental Health and prompted research into the subject of neuropsychiatric issues (Koyanagi, 2007). Then in 1963, President John Kennedy signed the Community Mental Health Centers Act into law (Koyanagi, 2007). This act provided funding for the construction of community-based preventive care and treatment facilities (Koyanagi, 2007). This act also detailed improvements in emergency care, 24-hour inpatient care, partial hospitalization, outpatient care, patient consultation, and patient education (Koyanagi, 2007). The goal of this piece of legislation was to provide patients with comprehensive community treatment of mental illness, as opposed to treating patients with mental illnesses in hospitals (Koyanagi, 2007). However due to the economic status of the United States during this time period, this program lacked adequate funding (Koyanagi, 2007). The development of Medicaid in 1965 also drastically changed funding for mental illnesses. This is largely because Medicaid excluded coverage for patients in mental institutions (Koyanagi, 2007). In 1980, President Jimmy Carter signed the Mental Health
Systems Act into law (Koyanagi, 2007). This act called for the reorganization of mental-health centers within the community and an increase in resources provided to individuals with mental illnesses (Koyanagi, 2007). However, President Ronald Reagan repealed this act in 1981, which decreased federal mental health spending by 25% (Koyanagi, 2007). These acts in combination with the budget cuts to mental healthcare ultimately led to the deinstitutionalization of mental healthcare.

The closing of state mental hospitals and discharging of patients with mental illnesses marked the deinstitutionalization of patients with mental illnesses. The goals of deinstitutionalization included decreased length of inpatient hospital admissions and increased community follow-up care (Koyanagi, 2007). However, deinstitutionalization had many negative effects, including: inadequate mental health services in the community, increased homelessness of individuals with mental illnesses, and a drastic increase in the number of individuals with mental illnesses in prison (Koyanagi, 2007). In the 1980s and 1990s, the nation’s focus shifted towards the high cost of healthcare and the need for cost containment. The focus of legislation at this time was the integration of individuals with mental illnesses into the community (Koyanagi, 2007). Individuals with mental illnesses also began to organize and speak out about problems with mental healthcare (Koyanagi, 2007). In addition, organizations such as The National Alliance on Mental Illness (NAMI) were also established during this time (Koyanagi, 2007). NAMI and other similar organizations worked to advocate for legislative changes in an attempt to improve the treatment of patients with mental illnesses (Koyanagi, 2007). There was also an increase in funding for research on the structure and function of the brain during the time (Koyanagi, 2007). This led to the development of many new medications to treat mental illnesses (Koyanagi, 2007).
Current Perspective on Mental Illnesses

The issue of treatment regarding patients with mental illnesses is still very prevalent in the United States today. Over the past fifteen years, there has been a dramatic decrease in both federal and state funding for treatment of patients with mental illnesses. In 2009, due to the poor economic condition of the nation, states eliminated over $4.35 billion in funding to mental health programs (Butlairie & Brown, 2012). In 1995, there were roughly 1,500 psychiatric units and 1,525 psychiatric hospitals in the United States (Butlairie & Brown, 2012). In the following ten years these numbers drastically decreased to only 300 psychiatric units and 450 psychiatric hospitals (Butlairie & Brown, 2012). As a result of these declines in funding and the current structure of healthcare in the United States, the emergency department becomes a ‘safety net’ for mental health patients requiring care (Butlairie & Brown, 2012). However, the emergency department is not an appropriate location for patients with mental illnesses, particularly patients experiencing a crisis. The emergency department is typically an unpredictable, unstable, noisy, and chaotic environment. This can lead to patients not receiving the one on one care they require in order to properly diagnose and treat mental illnesses. Also patients are more likely to become increasingly agitated in this type of environment, which could potentially escalate to violent behaviors. Most emergency department staff members are not appropriately trained to assess and treat patients with mental illnesses (Butlairie & Brown, 2012). This can lead to patients not receiving an acceptable level of care necessary to stabilize their condition. Patients with mental illnesses will also frequently present to the emergency department and then need to be transferred to a mental or behavioral unit for further treatment. However, due to the lack of bed in these units, patients can spend 48 hours or more in the emergency department waiting for a bed to become available (Zeller, Calma, & Stone, 2014). It is estimated that it costs $2,264 to
keep one patient with a mental illness in the emergency department while they wait for an available bed (Zeller et al., 2014). Also, treating patients with mental illnesses in the emergency department can become costly because the average length of stay for a patient with a mental illness is twice that of patients presenting with physical issues (Zeller et al., 2014).

The current model used in behavioral health is the four-quadrant model. The purpose of this model is to integrate patient’s mental and physical health, and identify patient needs for each quadrant (Substance Abuse and Mental Health Services Administration, 2015). This model divides patients into the following four quadrants: quadrant one – low behavioral health risk and low physical health risk, quadrant two – high behavioral health risk and low physical health risk, quadrant three – low behavioral health risk and high physical health risk, and quadrant four – high behavioral health risk and high physical health risk (Substance Abuse and Mental Health Services Administration, 2015). The individuals that present to the emergency department are generally in either the second, third, or fourth quadrant. Funding is generally largely dedicated to patients in the fourth quadrant because they generally have low medication adherence, higher incidences of co-occurring medical conditions, higher incidences of co-occurring drug and alcohol abuse problems, and more complex treatment plans. Patients in the fourth quadrant also typically require significant amounts of collaboration between multiple disciplines of healthcare (Substance Abuse and Mental Health Services Administration, 2015).

**Significance of the Clinical Problem**

It is estimated that one in about every four individuals in the United States has been diagnosed with a mental illness (National Alliance on Mental Illness [NAMI], 2013). This is equivalent to over 60 million adults in the United States. It is also estimated that one in every seventeen individuals will suffer from a major mental illness, such as schizophrenia or bipolar
disorder (NAMI, 2013). Mental illnesses are estimated to cost the United States over $193 billion dollars every year (NAMI, 2013). It is also estimated that 90% of individuals that attempted to commit or committed suicide had been diagnosed with at least one mental illness (NAMI, 2013). These statistics reveal that mental illnesses are very prominent in the United States and can become costly if not treated appropriately.

It is estimated that one in every eight emergency department visits will be related to patients with mental illnesses or substance abuse (Manton, 2013). This was equivalent to about twelve million emergency department visits in 2010 (Manton, 2013). These numbers have been trending upwards the past ten years (Manton, 2013). Due to this high volume of patients presenting to the emergency department, it is important that staff are adequately trained and protocols are established and implemented in order to provide the best possible care to patients with mental illnesses. Also, patients with mental illnesses are commonly treated in the emergency department, but they are discharged without referrals and lacking the knowledge of available resources (Buttlaire & Brown, 2012). The lack of services after treatment in the emergency department leads to high readmission rates to the emergency departments for patients with mental illnesses (Buttlaire & Brown, 2012).

Many studies and surveys of emergency department staff members reveal that the majority of these staff members do not feel comfortable providing care to patients experiencing an emergency mental health crisis (Manton, 2013). Studies reveal that emergency department staff members feel as though their education did not adequately prepare them to provide care for patients with mental illnesses (Manton, 2013). Staff members also feel as though there is a lack of clear institution guidelines for treating patients with mental illnesses (Manton, 2013). Staff
members state they feel they lack the knowledge, skills, and experience to adequately assess and treat patients with mental illnesses (Manton, 2013).

Another common trend in the literature is that some emergency department staff members hold biases against patients with mental illnesses. For example, patients have reported nurses making comments such as not believing that patients with mental illnesses have a serious diagnosis (Buttlaire & Brown, 2012). This can lead to an increase in patient agitation and an increased risk for patient violence directed toward staff members. Some staff members also report that they believe that patients with mental illnesses that have high readmission rates are “clearly time wasters” or are “attention seeking” (Goode, Melby, & Ryan, 2014, p. 34). Another study found that emergency department staff members frequently triaged patients with mental health illnesses at the bottom of the priority list (Innes, Morphet, O'Brien, & Munro, 2014). This is concerning and in need of attention because mental health problems should be prioritized similarly to physical health problems. Also, poor attitudes of staff members could lead to adverse patient outcomes.

Studies regarding violence in the workplace revealed that the emergency department has one of the highest risks for the occurrence of violence (Rees, Evans, Bower, Norwick, & Morin, 2010). In 2011, the Emergency Nurses Association (ENA) conducted a violence survey and found that in instances of patients becoming violent towards nurses, about 55% of the cases involved patients who were under the influence of alcohol and about 43% of the patients had a psychiatric diagnosis (Manton, 2013). Another study also revealed that 86% of emergency department staff members reported experiencing workplace violence and 20% stated they experienced workplace violence frequently (Rees et al., 2010). These statistics further reveal the importance of staff members being knowledgeable and confident in their abilities to recognize
signs of escalating behaviors and use of de-escalation techniques to keep agitated patients from escalating to violent behaviors (Manton, 2013). Additionally, the high risk for violence that is present in the emergency department can cause staff members to feel significantly less safe at work (Kowalenko et al., 2012). Staff members feeling fearful of experiencing violence at work can lead to decreased productivity and high turnover rates (Healy & Tyrrell, 2012). This can also lead to a decline in the quality of patient care because staff members’ fear can interrupt their focus and concentration on the patient and other nursing tasks (Healy & Tyrrell, 2012). Violence in the workplace can also be very costly to the hospital. It is estimated that the cost per case for assaults to registered nurse in 2011 was $31,643 (Gates, Gillespie, & Succop, 2011).

**Summary and Conclusion**

Treatment of patients with mental illnesses has been an issue in the United States for many years. Due to the recently increasing number of patients with mental illnesses presenting to the emergency department, proper protocols need to be established and implemented in order to ensure that adequate treatment is provided. Also, because of the increasing amount of violent events taking place in the emergency department, proper protocols need to be implemented and established to ensure that staff members feel safe.
CHAPTER 2
REVIEW OF LITERATURE

The purpose of this chapter is to review current literature regarding providing care to patients with mental illnesses in the emergency department setting. This review includes literature found from the Cumulative Index to Nursing and Allied Health Literature (CINAHL) online database and Pub Med Central (PMC) online database. Applicable multidisciplinary literature published between 2005 and 2013 was selected. Searches were conducted using the keywords: mental illnesses, emergency department, staff education, emergency department violence, and assessment of patients during psychiatric crisis.

Lack of Staff Education

Increasing staff education programs that include information of the subject of assessment and de-escalation interventions is a growing trend in the literature. In order to provide the best possible care for patients with mental illnesses in the emergency department, staff members need to feel knowledgeable and confident in their assessment and intervention skills. According to the ENA, no apparent guidelines on how to properly assess levels of agitation exist (Manton, 2014). Nurses that do not have experience working in mental health settings consistently report feeling as though they lack the knowledge to assess for signs of escalating behaviors and ability to verbally de-escalate patients with mental illnesses (Manton, 2014). The lack of this specialized knowledge has become a significant problem due to the increasing number of patients presenting to the emergency department while experiencing a mental health crisis. Therefore, increased staff education is an important factor in ensuring that appropriate care is provided to patients with mental illnesses. Studies regarding important components to be included in education programs were evaluated in order to develop the best practice protocol.
In a study conducted by Rutledge et al. (2013), 844 surveys were administered to nurses at three different hospitals in California. The survey assessed behavioral health nursing competencies in the following areas related to addressing and treating mental health issues: assessment, interventions, ability to recommend psychotropic medications, and adequacy of resources. The study found that nurses felt moderately strong in their assessment abilities, moderately strong in their abilities to intervene, moderately strong in their abilities confidence to provide adequate resources, and moderately weak in their abilities to recommend psychotropic medications. Nurses in the emergency department reported a slightly increased confidence in the selected behavioral health competencies when compared to other departments. However, their confidence could still be strengthened due to the current increase in the number of patients with mental illnesses presenting to the emergency departments. A strength of this study was that a large number of surveys were analyzed, thus increasing the generalizability of the results. However, one limitation of this study is that staff self-reported their confidence in performing their skills. This slightly weakens the results because there is no way of knowing the nurses’ abilities to actually perform these behavioral health competencies. The results of this study suggest that nurses could greatly benefit from increased education regarding implementation of interventions in patients requiring verbal de-escalation and recommendations of psychotropic medications.

Plant and White (2013) performed a qualitative study in which focus groups consisting of emergency department nurses were held. The transcripts from the focus group discussions were then analyzed for themes and categories. The major theme that emerged from the study was powerlessness. Specifically, nurses felt as though they faced challenges regarding not knowing what to do, faced many barriers in providing adequate levels of care, and frequently felt hopeless
as a result of not knowing what to do. In terms of not knowing, nurses felt as though they lacked the skills and knowledge needed in order to effectively communicate and provide care to patients with mental illnesses. The barriers faced also included a lack of education, as well as clear policies and procedures. Nurses also felt as though they were not able to provide adequate care to patients with mental illnesses as a result of not feeling confined in their knowledge and skills for providing care to this patient population. A strength of this study was that researchers in the focus group looked at the nurses’ verbal and nonverbal communication for cohesion. A limitation of this study was that the sample group was small and consisted of only females, which limits the generalizability of the results. In order to empower nurses to feel confident in their abilities to care for patients with mental illness, it is important that they are provided with the proper education and training to assess, intervene, and treat patients with mental illnesses.

In a qualitative study conducted by Kerrison & Chapman (2007), semi-structured interviews were performed in order to determine the concerns that nursing staff had in regards to taking care of patients with mental illnesses. This study found that nurses were not properly educated on mental health issues and lacked the ability to assess and communicate with patients with mental illnesses. Therefore, the study found that education programs should to be focused on workplace aggression and violence, mental health assessment, and chemical dependence. The study also found that one of the main concerns of nurses in the emergency department was their safety when providing care for patients with mental illnesses. The study also found that staff members believed that education programs focusing on workplace aggression, workplace violence, and chemical dependence would help to ease some of the staff members’ concerns. One strength of this study is that nurses from five different emergency departments participated in the interviews. This helps to increase the generalizability of the results to various emergency
department settings. However, a limitation of this study is that a small sample size was used, which can weaken the results. This study concluded that providing emergency department nurses with proper education in order to increases nurses’ abilities to assess and communicate with patients with mental illnesses is very important.

Nau, Halfens, Needham, and Dassen (2009) completed a study in which six nursing student classes were chosen to test the effectiveness of a training program on de-escalating aggressive patients. The nursing students were first given a simulation of an aggressive patient and their attempts to de-escalate the patient were video recorded. De-escalation experts then analyzed the video records for effectiveness. Half of the nursing students then received 24 hours of verbal de-escalation training that focused on prevention, assessment, student behaviors when interacting with the patient, and coping and aftercare. All the students then participated in another video recorded simulation of de-escalading an aggressive patient. De-escalation experts again analyzed the video records for effectiveness. The study found that the students that received the training performed significantly better in de-escalating the aggressive patient during the second simulation than the students that did not receive the training. A strength of this study is that a large sample comprised of different nursing schools was utilized, which increases the generalizability of the results. However, a limitation of this study was that simulations were utilized, which means that nursing students were expecting the patient to exhibit aggression. This is not necessarily realistic because aggression cannot always be predicted with complete accuracy. The results of this study suggests that training programs developed to teach aggression management, specifically prevention, assessment, student behaviors when interacting with the patient, and coping and aftercare could help to improve nurses’ ability to verbally de-escalate aggressive patients.
In a consensus statement by the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup (2012), the use of noncoercive approaches was promoted. The expert opinion in this workgroup as well as the literature that was reviewed supported the consensus that staff should be trained once a year on a three-step approach. The approach is as follows: verbally engage the patient, establish a collaborative relationship, and then verbally de-escalate the patient. The consensus statement then presents general guidelines for de-escalation and key recommendations. These guidelines include: ensuring the safety of the staff members at all times, being aware of body language, listening to what the patient is saying, working with the patient to develop plans of care, and offering the patient choices. The opinions of the experts included in this consensus statement believe that if the de-escalation techniques discussed in this article are appropriately taught and used by staff members then agitation of patients in the emergency department could be decreased and the risk for violence would then decrease as well. A strength of this article is that many experts on the topic of emergency psychiatry all collaborated to develop this consensus statement. However, a weakness of this study is that there was a lack of randomized controlled trials to support the consensus statement.

A thematic synthesis performed by Price and Baker (2012) examined the use of de-escalation techniques with patients with mental illnesses. The synthesis of 11 studies resulted in the emergence of seven different themes. The themes were: characteristics of effective de-escalators, maintaining personal control, non-verbal and verbal skills, engaging with the patient, when to intervene, and strategies for de-escalation. Specifics of each theme are further discussed in the article. The synthesis also discussed that limit setting and authoritative interventions should be used sparingly and cautiously, because these strategies have been found to worsen aggressive behavior. These interventions should only be used when a firmer approach is
necessary in order to maintain the safety of everyone involved. This synthesis also concluded that a consistent training program that teaches nurses about the process of de-escalation should be developed in order to attempt to decrease the incidence of violence. A strength of this synthesis is that many studies were analyzed, which increases the strength of the results and conclusions. However, the results are slightly weakened because the studies analyzed did not include a large number of trials performed under rigorous experimental conditions.

In a literature review performed by Beech and Leather (2006), the authors reviewed the prevalence of workplace violence and the current staff education programs available. The literature review found that trainings to prevent workplace violence were not prevalent and not consistent among healthcare workers. Beech and Leather then advocated for the implementation of training programs to manage workplace violence in the healthcare setting. The literature review then discussed that an integrated organizational perspective was necessary in order to decrease violence in the workplace. The review also discussed that a good training program should include prevention, how to interact with aggressive patients, and follow-up post violent incident. They also state that employees working with potentially violent patients, such as in the nurses in the emergency department, should be trained in defusing, de-escalating, and avoiding violent incidents. A strength of this review is that hospitals in both the United States and England were examined. This increases the generalizability of the results found in this review. However, a weakness of this study is that much of the literature reviewed is from before the year 2000. Thus some of the information in the review may not include the most up to date results and recommendations. This review concludes that workplace violence in healthcare is a serious issue and as a result adequate staff training programs that focus on particular identified needs are necessary in order to best manage this serious issue.
In a literature review completed by Wand and Coulson (2006), methods of decreasing aggression and violence in emergency department settings were explored. The literature review suggests that early recognition and utilization of interpersonal skills to defuse escalating situations is considered to be the preferred intervention method. Specifically, staff should be taught communication and negotiation strategies, as well as taught verbal de-escalation techniques that can be utilized to calm and re-direct agitated patients. According to Wand and Coulson, in order to effectively de-escalate patients, emergency department staff members need to be able to convey a message that they want to work with and collaborate with the patient to problem solve. The patient should additionally be told the potential consequences of his or her actions. The literature review also suggests that the use of restraints, both chemical and physical should be used as a last approach. A strength of this review is that the researchers differentiate what the ideal situation is from what is realistic. They recognize that certain methods, such as a zero tolerance approach, may not be realistic and so they modify their findings in order to make them realistic to implement in the hospital. However, a weakness of the review is that few randomized controlled trials were utilized in this review. The review concludes that early recognition, de-escalation, and safe restraint of escalating patients are key components of decreasing violence in the emergency department.

The trends in the literature reviewed revealed that staff members desire additional education in order to enhance their abilities to care for patients with mental illnesses. As a result of staff members desiring further education in order to enhance the care for patients with mental illnesses in the emergency department, it likely indicates that staff members would value the education programs. The literature also revealed that additional education should be specifically aimed at improving assessment abilities and use of verbal de-escalation for patient exhibiting
signs of agitation and aggression appropriate interventions. These education programs could ultimately help nurse to feel more confident in their abilities to assess and intervene, decrease their feelings of hopelessness, and increase their feelings of safeness.

**Broset Violence Checklists**

The Broset Violence Checklist is an assessment checklist that contains six items that can be used to predict for the risk for potential violence in patients. Three of the six items relate to patient characteristics and the other three items relate to patient behavior. The six items in the checklist are: confusion, irritability, boisterousness, physical threats, verbal threats, and attacking objects. Each of the six items are then scored and assigned a zero if the item is not present, or a one if the item is present. The score of each item is then added up and if the patient scored a zero, they have a small risk for violence. If the patient scores a one to two, they have a moderate risk for violence. Then if the patient scores higher than a two, they have a high risk for violence. If the patient is in the high risk for violence category, it is recommended that interventions be directed at that patient in order to maintain patient safety. This violence checklist has been tested many times on psychiatric units, but the accuracy of the tool has recently been validated in a study in the emergency department.

A prospective study performed by Vaaler et al. (2011), examined the ability of the Broset Violence Checklist to predict threatening and violent behavior of patients with mental illnesses in an acute psychiatric intensive unit. The study found that the Broset Violence Checklist was 58% effective in regards to predicting short-term violence in the psychiatric intensive care unit (Vaaler et al., 2011). The study deemed that 58% accuracy of predicting violence was statistically significant. This study also found that the Broset Violence Checklist was short, easy to administer, and practical for nurses to incorporate into their routine practice. Also, unit wide
use of this checklist was able to assist staff members in identifying patients that are at a high risk for violence and where they should focus preventative interventions. One strength of this study was that researchers talked to staff members everyday about the incidence of violence. This therefore decreases the chances of underreporting of violent incidences. However, a weakness of the study is that only one unit at one hospital was tested, therefore limiting the generalizability of the results. This study concluded that patients should be screened using the Broset Violence Checklist to predict short-term aggression. Additionally, the ease of administering this checklist as well as the short length of this checklist would make it a simple intervention that nurses could easily administer, even in a chaotic environment, such as that in the emergency department.

The finding in the Vaaler et al. (2011) study in regards to the predictive capabilities of the Broset Violence Checklist was validated for use in emergency department in the United States through a study performed by Sarah Knapp in 2013. Knapp (2013) studied the effects of implementing the use of the Broset Violence Checklist with patients in the emergency department. In this study, a survey was conducted pre-intervention in order to examine the number of violence incidences in the emergency department. The staff was then trained to use the Broset Violence Checklist and the checklist was implemented for use with all patients presenting to the emergency department. A post-intervention survey was then conducted to again examine the number of violent of violent incidences in the unit. The study found that there were about 35 violent acts pre-intervention and that number was reduced to only 27 violent acts post-intervention (Knapp, 2013). This suggests that the Broset Violence Checklist could be used by nurses in the emergency department to help focus interventions on specific high-risk risk patients. Another finding of this study was that the Broset Violence Checklist score could be used in hand-off report so that oncoming staff members can be warned about the potential risk
for violence. A strength of this study is that the results of this study were consistent with findings from other studies on the use of the Broset Violence Checklist. However, a weakness of this study is that a smaller emergency department was utilized, which could limit the generalizability of the results.

The literature available in regards to the use of the Broset Violence Checklist suggests that this quick and easy to use checklist is helpful for nurses to use while trying to predict patients that are at risk for becoming violent. However, it is important to note that no tool, including this tool, is 100% effective at predicting risk for violence in patients. The studies also found that training staff to use this checklist is manageable, and due to the quickness and ease of use associated with this checklist, it could easily be implemented in a chaotic unit such as the emergency department. Through the implementation of the Broset Violence Checklist in the emergency department staff could be more knowledgeable about where to focus verbal de-escalation interventions, which could potentially decrease the incidences of violence and staff members, could feel safer in the workplace.

**Current Staff Education Programs and Suggestions**

The literature review also encompassed current suggestions made by the Emergency Nurses Association and the United States Department of Health and Human Services in regards to improving care of patients with mental illnesses and decreasing the incidence of violence in the emergency department.

The ENA has declared that it is crucial “that best practices in the care of psychiatric patients in the emergency department be identified, documented and disseminated to both improve care of psychiatric patients in the emergency setting and also to provide for increased staff safety” (Manton, 2013, p. 1). One of the proposed suggestions made by the ENA is to
increase staff members’ comfort levels and attitudes for providing care for patients with mental illnesses in the emergency department. This can be achieved through increasing content on the subject of treating patients with mental illnesses in continuing education and professional development programs. Another suggestion made by the ENA is further research to establish best practices for the treatment of the aggressive, violent, or agitated patients in the emergency department. According to the ENA, this means using non-pharmacological de-escalation techniques to decrease agitation as opposed to utilizing seclusion and restraint methods. The ENA also emphasizes giving patients choices whenever practical and possible.

The Substance Abuse and Mental Health Services Administration (SAMHSA), in conjunction with the United States Department of Health and Human Services (2009), has also developed practice guidelines on the subject of responding to patients experiencing a mental health crisis. The guidelines outline ten essential values in appropriate crisis response. The ten values are: avoiding harm, intervening in person-centered ways, shared responsibility, addressing trauma, establishing feelings of personal safety, based on strengths, the whole person, the person as a credible source, recovery/resilience/natural supports, and prevention. The value of intervening in person-centered ways is particularly important because interventions need to “seek to understand the individual, his or her unique circumstances and how that individual’s personal preferences and goals can be maximally incorporated in the crisis response” (United States Department of Heath and Human Services, 2009, p. 5). Patients with mental illnesses do not necessarily have a typical patient presentation, and as a result nurses need to modify their care and interventions to each unique patient. Another core element for responding to mental health crises, according to this program, is helping the patient to regain a sense of control. According to this program, staff interventions that allow the patient to make choices may help the patient to
regain his or her sense of control. Staff member training programs utilized in hospitals should therefore contain these values and elements so that staff members are able to understand patients with mental illnesses not only through a clinical sense but also through “their lived experiences” (United States Department of Heath and Human Services, 2009, p. 13).

The current suggestions made by the ENA and the United States Department of Health and Human Services aligned with the results of the literature review. It is evident that increased staff education programs are an important factor in improving care to patients with mental illness in the emergency department and decreasing workplace violence.

**Debriefing**

Debriefing with staff members after stressful events occur, such as a violent event in the workplace, is another growing trend in the literature. According to studies, staff members should be encouraged to debrief after stressful events in order to prevent the development of adverse psychological effects (Gates et al., 2011). Individuals who experience violence in the workplace can suffer from many psychological problems, including loss of sleep, anxiety, helplessness, and flashbacks (Gates et al., 2011). In addition to the psychological problems that nurses can develop, the occurrence of violent events can also have adverse effects of nurse productivity. Therefore, as the literature suggests, it is important that hospitals implement effective debriefing programs to decrease the psychological effects of stressful events occurring and maximize the productivity of nurses in the emergency department.

Gates, Gillespie, and Succop (2011), conducted a cross-sectional study that aimed to determine how violence in the emergency department was related to productivity of nurses and the development of post-traumatic stress disorder (PTSD). The study examined 264 survey responses on the subject of violence in the workplace from emergency department nurses in the
Patients with Mental Illnesses in the ED

United States. According to the results of the survey, 94% of nurses experienced one or more PTSD symptom following a violent event (Gates et al., 2011). Also, 17% of nurses had scores high enough to be considered likely for PTSD (Gates et al., 2011). The results revealed a significant indirect relationship between stress symptoms and the productivity of nurses in the emergency department. There was also a relationship found between the occurrence of violence and the care that emergency department nurses provide. Despite these significant statistics, few nurses report participation in formal or informal debriefing processes following a violent event. As discussed in this study, interventions that take place hours to days after a violent event can provide the nurse with a necessary support system and assist in preventing the development of psychological problems following the event. The study also discusses that the debriefing process can give the nurse the opportunity to process what happened and put everything into perspective, which can then help the nurse to relieve stress and anxiety. As this study reveals, debriefing is a very important process to ensure that emergency department nurses do not suffer short or long-term psychological effects of encountering violence in the workplace. One strength of this study is that a demographically diverse population completed the surveys, thus increasing the generalizability of the results. However, the study was unable to measure the severity of the violent event that occurred. The severity of the event could be an extraneous variable that impacted the results.

A quasi-experimental study conducted by Blacklock (2012) examined the development of Critical Incident Stress Management Teams (CISM). CISM is a “strategic process designed to address critical incidents experienced by individuals in their workplace to help them deal with emotional trauma one incident at a time” (Blacklock, 2012, p. 2). As discussed in this study, if post-incident stress is not appropriately addressed, it can build up and lead to the development of
PTSD. As a result, the potential effects of emotional defusing within 24 hours of the event and formal debriefing within 72 hours of the event were examined. Emotional defusing is an informal support group facilitated by a mental health professional, is aimed at staff members that are directly involved in the event, and the goal is to ensure that staff members are able to continue with their shift. The formal debriefing is facilitated by a mental health professional, and staff members are invited to discuss their role in the event, their thoughts on the event, and the emotions they experienced during the event. During formal debriefing, staff members are also taught about signs and symptoms of stress and stress management techniques. In chaotic situations these two sessions were combined into one for increased time efficiency. The study then examined the effects of this debriefing process on hospital staff members that were involved in a critical event. The study found that after three months participants did not display any signs and symptoms of stress. This study concluded that the CISM debriefing processes were able to function as a support system to possibly protect staff members from developing additional stress. As this study demonstrates, it is important that nurses have a supportive environment to debrief following critical events to ensure that emotional trauma does not ensue. A strength of this study is that other studies on the subject of CISM found similar results. However, a weakness of this study is that only one hospital, after one critical incident, was examined, thus decreasing the generalizability of the results.

In a literature review conducted by Healy and Tyrrell (2013), critical events were thought to exacerbate staff stress and could impede their ability to provide quality patient care. The literature review determined that one method of managing staff stress after a critical event was to provide debriefing sessions. The literature review discusses that one study done in three emergency departments, 87% of emergency department staff thought debriefing after stressful
events was important (Healy & Tyrrell, 2013). Another study also found that 89% of staff members in the emergency department would like to have debriefing guidelines implemented (Healey & Tyrrell, 2013). As these statistics reveal, formal debriefing guidelines in the emergency department is a much needed service in order to help staff manage stress that can result from critical events. The literature reviewed in this article also suggests that mental health professionals should lead debriefing sessions and during the sessions staff members should be taught the signs and symptoms of stress and stress management techniques. The findings of this literature review suggest that emergency department staff members desire and would likely benefit from debriefing programs in order to improve stress management. One strength of this review is that all three of the studies examined found similar results. This therefore validates the results concluded in the review. However, since there were only three studies examined, the generalizability of the results could be limited.

The literature reviewed regarding staff debriefing after critical and stressful events, such as violence in the workplace, revealed that staff members could greatly benefit from the implementation of a debriefing program. The implementation of a debriefing program could help provide staff members with a safe environment to discuss the event and put the event into perspective. The program could also help staff members to effectively manage stress and therefore decrease their risk for developing adverse psychological effects.

**Summary and Conclusion**

Due to the increasing incidence of patients with mental illnesses presenting to the emergency department, there is a considerable amount of research taking place on the topic. Also, research has been taking place on the topic due to the increase in violence directed towards staff members. In order to enhance the treatment of patients with mental illnesses in the
emergency setting and improve staff safety, it is important that a protocol is developed and implemented. According to the literature, one method of enhancing treatment and preventing the escalation of violent behaviors is through careful assessments and early interventions. Therefore, it is important that staff members are appropriately trained to assess patients for any signs of agitation, knowledgeable about the varying levels of agitation, and confident in their abilities to utilize appropriate de-escalation interventions. It is also important that nurses identify patients that are at an increased risk for violence so they can direct where to focus preventative interventions. This literature review offers a basis for development of a best practice approach for treating patients with mental illnesses in the emergency department.
CHAPTER THREE

Best Practice Protocol: Treatment of Patients with Mental Illnesses in the Emergency Department

The purpose of this thesis was to develop an evidenced based, best practice, protocol for nursing care of patients with mental illnesses in the emergency department. Due to the current trends in the literature regarding increased violence and a decrease in feelings of staff safety, this protocol focuses on the development of an education program for nurses to identify patients at a high risk for violence, assess for signs of increasing agitation, and implement de-escalation techniques. Also, due to the current trends in the literature regarding debriefing after stressful events to prevent nurses from developing adverse psychological effects, the implementation of a debriefing program is also discussed.

The literature review presented in the previous chapter provided evidence for the creation of a training program for nurses to enhance their ability to identify high risk patients, assess for escalating behaviors, and intervene to verbally de-escalate patients. After reviewing a variety of studies presented in chapter two regarding the lack of staff education programs and staff members not feeling comfortable assessing and verbally de-escalating patients, it is believed that an important aspect of effective treatment of patients with mental illnesses in the emergency department is increasing nurses’ knowledge. If nurses in the emergency departments properly assessed patients with mental illnesses and quickly intervened for patients in crisis, the incidence of increasing aggression and violent acts could be decreased. Nurses should also be educated on the proper techniques to utilize if verbal de-escalation techniques are ineffective and the patient becomes aggressive or combative. The proposed protocol will also include a standardized tool to assess a patient’s risk for violence. This will assist the nurse in prioritizing where preventative
measures need to be directed. The last component of the protocol is the implementation of a debriefing process following violent events. The debriefing process will be lead by mental health professionals and will assist staff in processing the event and stress management. After reviewing several studies presented in chapter two regarding the importance of debriefing, it is believed that the implementation of a debriefing program will help nurses to better manage stress and decrease the risk for nurses developing PTSD.

A summary of the components to be included in staff trainings as a part of the proposed protocol is presented in Table 1. A summary of the components of the debriefing process is presented in Table 2. The definitions of the different levels of evidence as defined by the Agency for Healthcare Research and Quality is also provided in Table 3.

**Staff Education for Assessment and Intervention**

One goal of the protocol is that nurses will be able to promptly identify individuals with mental illnesses that are at an increased risk for violence. The proposed protocol will implement the use of the Broset Violence Checklist at triage in order to identify individuals that are at a small, moderate, and high risk for violence. The use of this tool has been over 63% accurate in predicting violence in patients (Townsend, 2014). The use of this tool will assist nurses in identifying and prioritizing where they need to direct preventative interventions.

This protocol will require nurses working in the emergency department to attend an educational program provided by the hospital. This training will include the components that are described in Table 1. Each component will be addressed and the staff will have a chance to ask clarifying questions. This education program will also include a detailed presentation of common signs and symptoms of increasing agitation levels that can lead to violent events. With this education nurses can help to identify patients that are experiencing increasing agitation and
employ verbal de-escalation techniques described in the education program with the hopes of preventing the patient from escalating to violence.

A trained employee who is responsible for staff development will organize the training and ensure that staff members attend as required. The number of violent events in the emergency department pre-intervention and post-intervention, as well as the results of staff surveys, will be used to measure the effectiveness of the training program.

**Debriefing**

Developing a debriefing program is also important in ensuring that nurses do not suffer from psychological problems and emotional trauma after a stressful event. The proposed protocol will implement a debriefing process that includes the components summarized in Table 2. The protocol will require that the hospital provide this service to all staff members after a stressful event, such as violence in the workplace, occurs. The protocol will also require that the hospital provide a mental health professional to lead the debriefing sessions. Staff members will be strongly encouraged to attend the debriefing processes, as they feel necessary.
### Table 1

**Best Practice Protocol Components of Nurse Educational Training**

<table>
<thead>
<tr>
<th>Components to be included in Training</th>
<th>Topics</th>
<th>In-Text Citation of Reference</th>
<th>Level of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Use of the Broset Violence Checklist</strong></td>
<td>- Identifying what the Broset Violence Checklist is</td>
<td>Knapp, 2013</td>
<td>Level IV</td>
</tr>
<tr>
<td></td>
<td>- Specific education on each six components of the checklist and how to properly identify each component</td>
<td>Vaaler et al., 2011</td>
<td>Level IV</td>
</tr>
<tr>
<td></td>
<td>- How to interpret scoring and each level of risk for violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Proper use the tool to focus where interventions should be directed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assessments</strong></td>
<td>- Physical symptoms of increasing agitation and aggression</td>
<td>Kerrison &amp; Chapman, 2007</td>
<td>Level VI</td>
</tr>
<tr>
<td></td>
<td>- Behavioral symptoms of increasing agitation and aggression</td>
<td>Plant &amp; White, 2013</td>
<td>Level VI</td>
</tr>
<tr>
<td></td>
<td>- Interview techniques for data gathering</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Assessing patients for risk factors for violence</td>
<td>Rutledge et al., 2013</td>
<td>Level VI</td>
</tr>
<tr>
<td></td>
<td>- Levels of escalating anger and aggression</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Communication strategies</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Assessing patients nonverbal communication</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Establish rapport and get to know patient individually

- Find a common interest with the patient and get to understand them as an individual
- Ask the patient their version of the story, what treatment they would like, what their preference are and what you can do for them
- Spend an adequate amount of time building a connection with the patient, building rapport with the patient will take time
- Provide trauma informed care – assess the patient’s history of and their recovery status from traumatic events, relate to their trauma history
- Tell the patient the truth

**United States Department of Health and Human Services, 2009**

### Restricting the use of setting limits on behaviors, instead offering the patient choices

- Do not aggressively set limits on patient’s behaviors
- Use permissive, non-authoritative approaches, as long at safety is not compromised
- Provide guidance without commanding or arguing with the patient
- Aim to empower the patient into staying in control and feeling as though they are choosing to de-escalate, as oppose to they are being forced to do something
- Avoid telling the patient what they need to do
- Patients should be informed of the consequences of their actions

**Price & Baker, 2012**

**United States Department of Health and Human Services, 2009**

**Wand & Coulson, 2006**
| Maintain personal safety | - Use the buddy system/team approach  
- Ensure personal access to exits at all times  
- Maintain at least 2 arms length distances away from patient  
- Be aware of surroundings and items that could be used as weapons |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------|
|                          | Beech & Leather, 2005  
Richmond et al., 2012  |
| Convey message to patient that you want to work together | - Be mindful of own nonverbal communication  
- Interventions should be done with patients, not to patients; patient should be treated as an active partner in their care  
- Teach new coping strategies and relaxation techniques  
- Offer alternatives  
- Suggest new responses  
- Offer patient a range of solutions  
- Practice active listening  
- Negotiate with patient and be willing to compromise  
- Remain calm  
- Exhibit patience, it may take 12 or more times repeating a message for the patient to hear what is being said  
- When physical interventions are used, it can reinforce the idea that violence is necessary to solve problems, thus they should be used as a last resort  
- Help the patient to regain a sense of control |
|                          | Beech & Leather, 2006  
Nau, Halfens, Needham, & Dassen, 2009  
Price & Baker, 2012  
Richmond et al., 2012  
United States Department of Health and Human Services, 2009  
Wand & Coulson, 2006  |
| Use Maslow’s Hierarchy of Needs | - Ensure basic needs are met before advancing up pyramid  
- Start with basic needs like food and water. The use of food can help to establish rapport with the patient  
- Initial interventions should establish feelings of personal and physical safety  
- Basic needs and safety must be met before rapport can be established and interventions can be effective | United States Department of Health and Human Services, 2009 | Level VII  
Wand & Coulson, 2006 | Level V  
Kerrison & Chapman, 2007 | Level VI  
Plant & White, 2013 | Level VI  
Richmond et al., 2012 | Level VII  
United States Department of Health and Human Services, 2009 | Level VII  
Plant & White, 2013 | Level VI  
Richmond et al., 2012 | Level VII  
United States Department of Health and Human Services, 2009 | Level VII |

| Reduce feelings of bias towards patients with mental illnesses | - Maintain an open mind, be empathetic with the patient  
- Do not judge patients  
- Positive attitudes can improve patient outcomes  
- Understand that the patient is doing their best in the present circumstances  
- Attitudes of staff members play an important role in patient care  
- Mental health needs are just as important as physical needs  
- Interventions should maintain the dignity and respect of the patient  
- Respect the legal rights of the patient | | | | | | | | | | |
### Progressive behavior control methods

- Proper use of restraints, both physical and chemical, and ensuring that staff understand orders and documentation of restraints
- Methods to employ when patients become physically violent
- Utilizing hospital security to ensure the safety of everyone involved
- Team approaches should always be used when behavior progressive behavior control methods need to be utilized, never independently use these methods

<table>
<thead>
<tr>
<th>Resource</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beech &amp; Leather, 2006</td>
<td>Level V</td>
</tr>
<tr>
<td>Wand &amp; Coulson, 2006</td>
<td>Level V</td>
</tr>
</tbody>
</table>
### Table 2

*Best Practice Protocol Components of Debriefing Process*

<table>
<thead>
<tr>
<th>Components of Debriefing Process</th>
<th>In-Text Citation of Reference</th>
<th>Level of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take place immediately to 72 hours after violent event</td>
<td>Blacklock, 2012</td>
<td>Level V</td>
</tr>
<tr>
<td></td>
<td>Gates et al., 2011</td>
<td>Level VI</td>
</tr>
<tr>
<td>Lead by a mental health professional</td>
<td>Blacklock, 2012</td>
<td>Level V</td>
</tr>
<tr>
<td></td>
<td>Healy &amp; Tyrrell, 2012</td>
<td>Level V</td>
</tr>
<tr>
<td>Provides a supportive environment for staff to process what happened and put things into perspective</td>
<td>Gates et al., 2011</td>
<td>Level VI</td>
</tr>
<tr>
<td>Staff members can discuss their role in the event and their thoughts and emotions of the event</td>
<td>Blacklock, 2012</td>
<td>Level V</td>
</tr>
<tr>
<td>Teaching of signs and symptoms of stress and stress management techniques</td>
<td>Blacklock, 2012</td>
<td>Level V</td>
</tr>
<tr>
<td></td>
<td>Healy &amp; Tyrrell, 2012</td>
<td>Level V</td>
</tr>
</tbody>
</table>
Table 3

*Levels of Evidence Defined*

<table>
<thead>
<tr>
<th>Level of Evidence</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I</td>
<td>Evidence obtained from a systematic review or meta-analysis of all relevant randomized controlled trials (RCTs) or evidence-based clinical practice guidelines based on systematic review of RCTs</td>
</tr>
<tr>
<td>Level II</td>
<td>Evidence obtained from at least one well designed RCT</td>
</tr>
<tr>
<td>Level III</td>
<td>Evidence obtained from well designed control trials without randomization</td>
</tr>
<tr>
<td>Level IV</td>
<td>Evidence obtained from well-designed case control studies and cohort studies</td>
</tr>
<tr>
<td>Level V</td>
<td>Evidence obtained from systematic literature reviews of descriptive and qualitative studies</td>
</tr>
<tr>
<td>Level VI</td>
<td>Evidence obtained from a single descriptive or qualitative study</td>
</tr>
<tr>
<td>Level VII</td>
<td>Evidence obtained from the opinion of authorities and/or reports of expert committees</td>
</tr>
</tbody>
</table>

*Note:* Adapted from Burns, Rohrich, and Chung (2011).
Summary and Conclusion

The best practice protocol stated above aims to educate nurses and provide them with opportunities to debrief after violent events in order to enhance the care patients with mental illnesses receive in the emergency department and improve feelings of staff safety. This will be achieved by educating nurses on how to assess individuals with mental illnesses and provide appropriate de-escalation interventions in the hopes of reducing the incidence of violent events in the emergency department. The protocol also provides guidelines on what should be included in debriefing sessions in order to provide staff members with a safe location to process the event and provide them with stress management techniques. Through the implementation of this protocol, it is the goal that nurses will feel more comfortable working with patients with mental illnesses and more effectively verbally de-escalate patients exhibiting increasing agitation. Therefore, this protocol could potentially decrease the incidence of violence in the emergency department and increase feelings of staff safety. The increased feelings of staff safety in combination with the debriefing process could also potentially lead to decreased staff stress and increased productivity. Further guidelines for implementation and evaluation will be discussed in the next chapter.
CHAPTER FOUR
Implementation and Evaluation

The purpose of this thesis was to propose a best practice protocol for improving the
treatment of patients with mental illnesses in the emergency department. This chapter presents a
theoretical plan to implement and evaluate the effectiveness of the staff education program, use
of the Broset Violence Checklist, and availability of debriefing processes. The developed
protocol can be implemented at any facility that does not have a sufficient staff education
program in place or is seeking an updated staff education program to implement in order to
improve care of patients with mental illnesses in the emergency department. The protocol can
also be implemented at any facility that does not have a sufficient debriefing program
established.

Diffusion of Innovation

The basis for implementation and evaluation of the proposed best practice protocol
derives from Roger’s Diffusion of Innovation. This five-step model includes the steps of
knowledge, persuasion, decision, implementation, and confirmation (Kaminski, 2011). These
five steps will be applied to put implementation of the staff education program, use of the Broset
Violence Checklist, and availability of debriefing processes into practice.

Knowledge

The knowledge stage of the Diffusion of Innovation Model is described at the time when
staff members are first exposed to an idea (Kaminski, 2011). At this point, they lack information
about the idea but have not yet felt the desire to find out more about the idea (Kaminski, 2011).
The decision makers necessary to implement this protocol for emergency department nurses
include the emergency department nursing manager and the house supervisor. Both of these
positions work to ensure that staff members feel safe and comfortable in the workplace. The quality improvement and risk management committees would be responsible for further evaluation and implementation of the protocol for additional emergency department staff members beyond just the nursing staff. The chief nursing officer and board of directors would also be involved throughout the process of implementation and evaluation by granting approval of the protocol and overseeing implementation.

At the beginning of the knowledge phase, an assessment must be completed to determine the number of violent events taking place in the emergency department and staff feelings regarding their own personal safety. Assessing the number of violent events taking place in the emergency department would be achieved by reviewing incident reports. Also, since it is known that many violent incidences are not correctly reported, surveys would also be utilized. Surveys would be used to assess for both the number of violent events and feelings of staff safety. This survey will include questions regarding: the number of violent encounters the staff members have had in the past month, how safe they feel coming to work, and how confident they are in their abilities to verbally de-escalate patients. The results of this assessment can then assist in determining the degree of the problem. The results of this assessment can also assist managers and administrators to recognize the importance of implementing a staff education program to improve treatment of patients with mental illnesses in the emergency department. Managers and administrators can also speak with individual nurses if they desire to gain more knowledge on the subject. Staff nurses will also be introduced to the idea of changing staff education programs and implementing debriefing processes at this time. The emergency department nurse manager and house supervisor will then evaluate the nurses’ responses to the idea. This will help the nurse manager and the house supervisor to predict how much resistance to change the
implementation of this protocol is likely to experience. The emergency department nursing manager and house supervisor can then present the results of this assessment at a committee meeting regarding safety and quality improvement. Stakeholders of the organization, including, but not limited to: staff nurses, charge nurses, nurse managers, house supervisors, chief nursing officer, leadership teams, executives on the board of directors, and the risk management committee will all be invited to attend the above committee meeting.

During this meeting, the emergency department nursing manager and house supervisor would present the material covered in this thesis in a PowerPoint presentation with additional statistics specific to the institution where the presentation is taking place. These statistics would be calculated from the results of the assessment that was previously completed. The degree of the problem can also be emphasized during this presentation by using quotations gathered from nurses in the emergency department. The primary goals of this meeting are: to educate the stakeholders of the significance of the problem, to emphasize the lack of effective education programs for staff members in caring for patients with mental illnesses in the emergency department, and to gain approval and support to begin the implementation process.

Implementation of an effective staff education program is necessary in order for emergency department nurses to be able to accurately assess, verbally de-escalate, and treat patients with mental illnesses. The requirement would be that 100% of emergency department nursing staff would attend two eight hour training days for instruction on providing care for patients with mental illnesses. These training days would be lead by an individual who has been trained to teach the education program. There would be at least six staff education programs offered in the months leading up to the implementation of the protocol. This would give nurses an appropriate time to plan and attend training before the protocol is implemented. The trainings
would then be held at least twice a month for newly hired staff members and staff that need to update their skills and knowledge. Additionally, debriefing processes are necessary to ensure that staff members are able to appropriately manage stressful events. The requirement would be that the hospital makes debriefing processes, lead by a mental health professional, available to all staff members for up to 72 hours after the stressful event. Staff would not be required to attend the debriefing process, but they would be strongly encouraged to attend.

This educational program will also present how the proposed protocol is expected to decrease workplace violence and increase staff safety. This component of the presentation is necessary to begin the persuasion stage. Throughout the education program, nurses will also have the opportunity to ask clarifying questions.

**Persuasion**

In the persuasion stage, staff members are interested in the idea and they have a desire to learn more about the idea (Kaminski, 2011). During this stage, the potential benefits of the protocol and how the protocol’s goals align with the hospitals missions, vision, and values would be explained to nurses. Potential feelings of increased staff safety would be emphasized as a benefit of this protocol as it is the likely the most persuasive benefit for staff members. Staff members will also be told that the debriefing processes available can help them to more effectively manage stress because this will likely be a persuading factor as well. In order to further persuade staff members, it will also be discussed that increased feelings of staff safety and utilizing debriefing processes can lead to decreased stress, increased productivity, improved quality of patient care, and decreased feelings of burnout. Also, increased patient safety will be emphasized as it aligns with the Joint Commission’s National Patient Safety Goals.

It is also very important that at this stage, all managers and administrators support the
protocol so that staff members will follow suit. If managers and administers are unified and positive about the implementation of this protocol, then it will be more likely that other staff members will be positive about the protocol as well. Also, managers and administrators can be very influential in encouraging interest and acceptance of change.

Another important factor during the persuasion stage is that staff members have access to reliable information. To provide reliable and consistent information, written information will be emailed to all staff members. Staff members would be emailed a brief copy of the protocol that outlines the components of the protocol and the major changes that can be expected with this protocol. Written communication strategies, such as email, would ensure that everyone receives the same information and that the information can be referred back to in cases of confusion.

Decision

During this stage, staff members look at the advantages and disadvantages of the idea and decide to either accept or reject the idea (Kaminski, 2011). In this protocol, hospital managers and administrators would determine if education programs, the use of the Broset Violence Checklist, and availability of debriefing processes are feasible and beneficial to implement. Factors that would be taken into consideration during decision making would be cost for the education programs, availability of a room for the education program to take place in, time that it would take to train nurses and other staff members, cost to pay nurses to attend the training, cost for using mental health professionals for debriefing, availability of mental health professionals for debriefing processes, and availability of a location for debriefing to take place. Additionally, staff members would decide to accept or reject the use of an education program, the Broset Violence Checklist, and debriefing processes. Factors that would be taken into consideration as staff members decide to accept or reject the protocol would be if they thought the training would
be beneficial, if they had the time to attend the training, how much additional work it would take to implement the protocol into their routine practice, and if they believe the debriefing processes would be beneficial.

The decision must also be accepted or rejected in the emergency department and hospital leadership. After looking at the significance of the problem and performing a cost/benefit analysis, the emergency department nurse manager would decide if the unit would adapt the protocol. The Chief Nursing Officer and the board of directors would also have to approve the protocol.

**Implementation**

This stage is described as when the staff member utilizes the idea and decides the usefulness of the idea (Kaminski, 2011). During this stage, nurses would decide to attend the education training, use the Broset Violence Checklist, and utilize available debriefing processes. Nurses would also not only attend the education training, but this stage would also require that nurses change their behaviors and implement what they learned at the training into their routine practice. It would be expected that nurses would consistently perform continual assessments of patients, use Maslow’s Hierarchy of Needs when planning interventions for the patients, work to establish rapport with the patient, offer the patient choices, and collaborate with the patient when providing care for patients with mental illnesses in the emergency department. Nurses would be implementing the protocol at varying degrees depending on the situation.

During this stage the nurses, managers, and hospital administrators would also decide if the protocol is useful or not. In order to evaluate the usefulness and effectiveness of the protocol, the assessment used at the beginning of the process to determine the number of violent events taking place in the emergency department and staff feeling safe would be repeated.
Assessing the number of violent events taking place in the emergency department would be achieved by reviewing incident reports. Also, since it is known that many violent incidences are not correctly reported, surveys would also be utilized. Surveys would be used to assess for both the number of violent events and feelings of staff safety. This survey will include questions regarding: the number of violent encounters the staff members have had in the past month, how safe they feel coming to work, and how confident they are in their abilities to verbally de-escalate patients. The results of the assessment pre-intervention and post-intervention would then be compared for effectiveness. If further data is wanted or needed, managers and supervisors could speak with individual nurses in the emergency department.

**Confirmation**

During this stage, staff members confirm their decision to continue to use the idea or not (Kaminski, 2011). In this stage, staff members could continue to maximally use this protocol in their practice. It is again expected that nurses would change their behaviors and incorporate the components of the staff education program into their routine practice. It is estimated that at the beginning, 50% of nurses would use the protocol in the practice because some would be resistant to change and others would forget aspects of the education program. However, it is expected that over one year, 90% of nurses the time will maximally use the protocol. Throughout the one-year, nurses can maintain a positive attitude about the implementation of the protocol in order to promote change and can help each other to learn to use the protocol. The effectiveness of the protocol will also be confirmed using the methods described in the implementation stage.

**Strengths and Limitation**

A strength of this best practice protocol is that after speaking to many emergency department staff members and thoroughly reviewing the literature, a need for improving
treatment of patients with mental illnesses in the emergency department and increasing feelings of staff safety was strongly indicated. Additionally, many of the studies reviewed resulted in the same findings, therefore strengthening the results of this thesis. Also, several expert opinions were obtained that confirmed the findings of the literature review.

A limitation of this thesis includes a lack of quantitative data. Most of the available data regarding this topic is qualitative. While qualitative data is still important, it is not quite as strong as quantitative data. Additionally, many of the studies reviewed did not contain control groups in their experimental designs.

**Recommendations for Future Research**

Recommendations for future research include conducting studies to determine the optimal environmental components when treating patients with mental illnesses in the emergency department. Studying this topic could help to identify environmental triggers that stimulate increasing agitation. Another topic for further research could be medication administration with this patient population. Studies aiming to discover the optimal time to administer medication to patients so that patients do not feel disrespected but violence also does not ensue as a result of waiting too long to intervene with medication. Research in these areas could help to further develop best practice protocols for improving treatment of patients with mental illnesses in the emergency department.

**Summary and Conclusion**

The purpose of this thesis was to develop evidence based recommendations for best practice in nursing care of patients with mental illnesses in the emergency department. Current research and opinions of staff members suggested that staff members lacked the confidence to provide appropriate care for patients with mental illnesses in the emergency department and that
violence directed towards staff has been increasing in the emergency department. The literature review that was conducted supported the implementation of education programs, the use of the Broset Violence Checklist, and the availability of debriefing processes. In conclusion, this protocol was developed to improve treatment of patients with mental illnesses in the emergency department and to increase staff feelings of safety in the workplace.
References


